CLARK COUNTY REGIONAL SUPPORT NETWORK
Pre-paid Inpatient Health Plan

UTILIZATION MANAGEMENT PLAN

I. Overview

A. Purpose and Scope

The Clark County Regional Support Network (CCRSN) manages the resources of its Pre-paid In-patient Health Plan through the Utilization Management (UM) Plan. The purpose of the UM Plan is to provide clear policies and procedures to CCRSN care management staff and to CCRSN contracted providers regarding requests for and authorization of payment of covered mental health services as well denials of service requests.

The UM Plan also provides a framework for monitoring over and under utilization, by identifying outliers, and evaluating trends of service delivery for quality improvement.

B. Utilization Management Program Components

The CCRSN Utilization Management Program includes the following components:

a. *Authorization*- Care Manager review of financial and clinical eligibility criteria and data completeness in the CCRSN information system (IS) to determine eligibility for Medicaid covered services and level and element of care (authorization type) as defined in the CCRSN Level/Element of Care Clinical Guidelines.

b. *Re-authorization*- Care Manager review of updated clinical and service data required for continued stay and appropriate level/element of care.

c. *Authorization of change of level/element of care*- Care Manager review of required clinical and financial data in the CCRSN IS upon receipt of provider request to change element of care.

d. *Consultation and Referral*- Care Manager consultation with allied service providers, advocates, families and/or consumers regarding access to Medicaid covered mental health services and referrals to CCRSN contracted providers.

e. *Case Consultation*- Care Manager review of clinical issues related to UM: consistency in interpreting Access to Care Standards, level/element of care decisions, etc.

f. *Utilization Reviews*- Care Manager and Quality Manager reviews of provider clinical records to assure documentation of medical necessity and clinical

eligibility criteria consistent with Access to Care Standards and CCRSN level/Elements of Care.

g. *Utilization Management Committee*- - An internal clinical, financial and IS review committee that defines needed UM reports and reviews for on-going UM reports for outliers, trends for the purpose of managing over and under utilization.

C. Staffing and Oversight

CCRSN Care Managers receive clinical supervision from the CCRSN Clinical Manager and Medical Director. Clinical supervision occurs weekly on a regularly scheduled basis, during daily morning triage and as needed. Care Managers meet bi-monthly with the Medical Director for case reviews and training. Care Manager Decisions about in-patient psychiatric admissions of children or youth are always reviewed with the CCRSN Medical Director before their decision is final. The CCRSN Quality Manager (UM Committee) provides information and feedback to Care Managers about internal consistency in authorization decisions and identifies trends in service utilization by level/element of care.

II. Authorization of Covered Services

A. Out-patient Authorization Policies and Procedures

1. CM04 Authorization for Outpatient Services
2. CM06 Intensive Element of Care Authorizations and Reauthorization/Change in Element of Care
4. CM07 Eligibility Criteria & Access to Care Standards - Adult
5. CM07-A Access to Care Standards - Adult
6. CM08 Eligibility Criteria & Access to Care Standards - Child
7. CM08-A Access to Care Standards -Child
8. QM05 Level/Elements of Care Clinical Guidelines

B. In-patient Authorization Policies and Procedures

1. CM18 Inpatient Services - Concurrent Review & Discharge Planning
2. CM19 Inpatient Services Authorization
3. QM05 Level/Elements of Care Clinical Guidelines

C. MIS Policies and Procedures

1. 2.02.04 Authorization for Treatment
2. 2.02.05 Modalities and Service Codes

III. Denial, Limitation, Reduction, Suspension, Termination of Care Policies and Procedures

1. CM03 Notice of Action
2. CR05 Consumer Rights to an Administrative Hearing
3. CR06 Consumer Rights to Appeal

IV. Utilization Review and Monitoring Triggers:

a) Crisis Bed Utilization
- Utilization Management Report weekly
- Enrollee Treatment History weekly
- Service Detail Report weekly

b) Residential Utilization
- Utilization Management Report monthly
- Enrollee Treatment History monthly
- Service Detail Report monthly

c) Crisis Services
- Individuals with 4 or more crisis services w/in 30 days

d) Utilization Management Report over/under
- Utilization Report by authorization type monthly
- Enrollees with move than 12 hours/month or less than 1 hour a month

e) Inpatient Readmission
- Inpatient Summary Report Monthly
- 30, 60, 90 days readmissions

f) Dual Disorders at Intake
- Impairment 1, 2, 3
- Axis I-I
- Axis I –II
- Axis I-111

g) Intensive Level/Element of Care Utilization Management
- Utilization Management Report Monthly
- Enrollee Treatment History Monthly
- Service Detail Monthly

h) Prescriber Usage
- Productivity Report
- Narrowed down to prescribers only

Clark County RSN Utilization Management Plan
FY2005-06 UM Work Plan Addendum

Concurrent Review Frequency

Clark County RSN has determined that Care Managers should conduct concurrent reviews of utilization at the frequencies defined in the following table:

Level of Care	Frequency of Review
Intensive Service Levels	
Inpatient Psychiatric Care	Up to 4 days, except ITAs reviewed 24 hours, then 72 hours, 14 days per statute
Freestanding Evaluation and Treatment	This level of care not available until 2006; UM Committee will define criteria likely to be similar to Inpatient Criteria
Residential Care	Up to 30 days
Stabilization Services	Up to 4 days
High Intensity Treatment / Children's Intensive Services Element	Up to 30
Day Support	Up to 7 days
Routine Outpatient Levels	
Adult Outpatient Care (inclusive of all outpatient service types)	Every six months when reauthorization requested (90 days for Brief Intervention Treatment), but sooner if trigger criteria specified below in Section 3.4.24.2.3 for more frequent review met
Child Targeted and Universal Services Elements (inclusive of all outpatient service types)	Every six months when reauthorization requested (90 days for Brief Intervention Treatment), but sooner if trigger criteria specified below in Section 3.4.24.2.3 for more frequent review met
Medicaid Personal Care	CareManager reviews every month and reauthorizes however this is a paper authorization and isn't in the CSM system. Every six months when reauthorization requested (90 days for Brief Intervention Treatment), but sooner if trigger criteria specified below in Section 3.4.24.2.3 for more frequent review met

UM Triggers Methodology

Clark County RSN has determined that the following triggers will result in a concurrent review of authorization, unless a review has occurred in the past 30 days:

- **Inpatient Readmission** – All cases readmitted to an inpatient level of care at the 30, 60 and 90 day points trigger enhanced Care Manager review and support. In addition, any consumers with two (2) or more hospitalizations in a year are triggered for review.
- **Crisis Service Over Utilization** – Crisis services are by nature responsive to situations that are out of control. While many people need repeated crisis supports, this can also be a sign of inadequate care planning or ineffective or inadequate service availability. Therefore, Clark County RSN seeks to identify cases using exceptionally high levels of crisis care and offer enhanced Care Manager review and support for these cases. Triggers include:
    - Use of four (4) or more crisis services within a 30 day
    - Readmission to a crisis bed within 30 days
    - Three (3) or more admissions to a crisis bed in a 6 month period
- **Crisis Care Under Utilization** – The primary focus here is on ensuring the development of crisis plans for high need consumers, as well as entry of those plans in the CSM information system. On intake, a high-risk screen has to be completed to determine if a consumer is identified as high-risk. If determined at high-risk based on criteria, a crisis plan must be completed within 14 days. This is formally reviewed monthly by the Care Managers in the CSM system. During the twice annual clinical reviews conducted with each provider, all crisis plans for high risk consumers will be identified, if missing in the clinical chart; the provider will be out of compliance and issued a corrective action plan. Any individual consumers identified as out of compliance will trigger enhanced Care Manager review of their case.
- **Residential Care Over Utilization** – Aggregate CSM data on residential care trends are reviewed monthly and the following cases identified for enhanced Care Manager review and support:
    - Readmission to a residential bed within 30 days
    - Cases identified during monthly reviews of residential bed utilization as staying more than two standard deviations over the average length of stay.
- **Over or Under Utilization at Any Level of Care** – On a weekly basis, total services received for all active authorizations at each level of care are reviewed by network provider. Services used by all actively authorized cases are summarized and ranked from highest to lowest. Any cases receiving more than two standard deviations beyond the average service hours for a level/element of care after 30 days or less than two standard deviations below the average use after 90 days trigger enhanced Care Manager review and support.
- **Co-occurring mental health and substance abuse disorders** – All consumers identified at intake with co-occurring mental health and substance abuse disorders are identified and enhanced Care Manager review and support triggered.
- **Prescription patterns** – All consumers requesting access to multiple network prescribers of psychiatric medication are identified and their cases trigger enhanced Care Manager review and support. In addition, any consumers identified through the twice-annual provider chart reviews as having been prescribed four or more psychotropic medications at any one time during the last a six month period trigger enhanced Care Manager review and support. A pattern of such utilization by a single provider may also trigger enhanced review of

prescription patterns more generally with that provider.

- **Missed Appointments** – Any consumers missing follow-up appointments post-discharge from episodes of 24-hour care or otherwise missing three (3) or more outpatient appointments of any type trigger enhanced Care Manager review and support. In addition, any active authorization for which care has not been delivered in a 60 day period is identified for Care Manager follow-up and investigation.
- **Sentinel Events** – Any consumer case involved in a sentinel event immediately triggers enhanced Care Manager review and support upon notification of the RSN
- **State Hospital Use** – All Clark County residents receiving services at Western State Hospital trigger enhanced Care Manager review and support during their stay and for at least six months year post-discharge.
- **Requests for Multiple Providers** – Any request for care from multiple network providers triggers enhanced Care Manager review and support.